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each other and the conditions under which they occurred. The result of this epidemiologic study of reported cases carried on for the past five years under the direction of Dr. Mark W. Richardson, secretary and executive officer of the board, suggested strongly the possibility of the disease being transmitted by the biting stable fly (*Stomoxys calcitrans*). To clear up this point Prof. M. J. Rosenau, of the Harvard Medical School, undertook a series of experiments and succeeded in transmitting the disease in monkeys by this biting fly. As noted in last week's issue of the Public Health Reports, Anderson and Frost have confirmed Rosenau's work and successfully transmitted the disease to monkeys by first letting these flies bite infected monkeys and then bite fresh monkeys.

From the standpoint of the control of the disease, these findings are of the greatest importance. While the demonstration that the disease can be transmitted in this way does not preclude the possibility that it may be transmitted also in other ways, common experience in the diseases found to be transmitted by an intermediate insect host or vector has been that such transmission has been in most cases the only one demonstrable. The discovery that poliomyelitis may be spread by the stable fly gives health authorities a tangible basis for their efforts to control the disease. It suggests that effective screening to keep flies from the sick will prove of paramount importance, and that other forms of quarantine may be unnecessary. It gives added importance to the cases of paralysis in animals frequently reported in localities where cases of poliomyelitis have occurred in man and gives an additional reason for the careful screening of buildings, the regulation of the maintenance of stables and the keeping of animals in cities, and the prevention of conditions making possible the breeding of flies.

Buffalo, N. Y.—The outbreak of poliomyelitis at Buffalo continues to subside. During the week ended October 26 only 6 cases were reported. The disease continues present to some extent in many localities in the western counties of New York State. Only a few cases, however, are being reported in any locality. With the advent of cold weather the disease will probably disappear.

OUTBREAK OF SEVEN-DAY FEVER IN THE CANAL ZONE.

By J. C. Perry, Surgeon, United States Public Health Service.

History.—The outbreak of seven-day fever began during the last few days of May. From May 23 to June 30 there were admitted to Ancon Hospital 24 cases. The first cases came from the Ancon post office, 5 being admitted from this place in rapid succession; 15 other cases were admitted during June from the bachelors' quarters (residence building) across the street from the post office. Dr. W. E. Deeks, chief of the medical clinic of Ancon Hospital, recognized the fever as not malarial, although at first it was considered that a severe localized outbreak of that disease had occurred without any apparent reason, as no anopheles mosquitoes were found in the vicinity.

The occurrence of cases as treated in Ancon Hospital was as follows:

	Cases.
May 23 to June 30	24
July	8
August	7
September	4
Total	43

Practically all of the cases were from Ancon—the post-office building and two bachelors' quarters. At a later period 4 cases were admitted from Balboa, two miles distant from Ancon, and 3 cases from the line of the railroad, one of which was from Gorgona, one from Corozal, and one from Pedro Miguel.

All of the cases were in adults—American or European—only two of whom were women. No cases occurred among the Spanish or Italian laborers, or negroes.

Investigation in Panama shows that during the outbreak at Ancon in June a few cases occurred in the city of Panama—a total of 12 cases during June and July. Most of these cases were among foreigners, although 3 cases occurred in natives, in ages varying from 6 to 20 years. There have been no cases in Panama for the past 30 days, and none admitted to Ancon Hospital for three weeks. No cases have been reported in Colon, Cristobal, or adjacent territory.

Symptomatology.—The outset is sudden, without prodromal symptoms. The disease is generally ushered in with a chill and a rise of temperature to 102° to 103°, although one or two cases had a temperature of 105°.

The face is flushed and the conjunctiva injected. There is severe backache and generally frontal headache. There is sometimes nausea, but seldom vomiting. The fever is continuous, with remissions for a period of six days, when a termination by slow crisis (12 to 14 hours) occurs. The pulse is slow, and the ratio to the increased temperature is not maintained. The tongue is coated, but there is nothing characteristic about the bowels; there is generally constipation, but there may be diarrhea. The gums are negative, not hemorrhagic, and there is little, if any, stasis of the cutaneous circulation.

The urine is negative in the majority of cases. Occasionally there is a trace of albumen, which is, no doubt, febrile, and does not appear or exist at any particular stage of the disease.

Rash occurred in 50 per cent of the cases, and was confined to the legs, feet, forearms, and hands. In a few of the cases it was of a fine, petechial character.

The disease seems identical with that described by Castellani as occurring in India and Ceylon, although the termination of the fever in the cases observed here occurred in six days.

I observed a number of these cases during the outbreak, especially those first reported, and they conformed to the clinical picture given above. The disease was not dengue, and there was nothing about the course of the disease that simulated yellow fever.